

INHERITED EYE DISORDERS TESTING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____
 Address _____ City _____ State _____ Zip _____ Phone _____
 Accession # _____ Hospital / Medical Record # _____
 Patient discharged from the hospital/facility: Yes No
 Biological Sex: Female Male Unknown
 Gender identity (if different from above): _____

REPORTING RECIPIENTS

Ordering Physician _____ Institution Name _____
 Email (Required for International Clients) _____ Phone _____ Fax _____

ADDITIONAL RECIPIENTS

Name _____ Email _____ Fax _____
 Name _____ Email _____ Fax _____

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

SELF PAYMENT
 Pay With Sample Bill To Patient
 INSTITUTIONAL BILLING

Institution Name _____ Institution Code _____ Institution Contact Name _____ Institution Phone _____ Institution Contact Email _____

INSURANCE
 Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____	State _____ Zip _____	City _____	State _____ Zip _____
Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	Secondary Member Policy # _____	Secondary Member Group # _____

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name _____ Patient's Signature _____ Date (MM / DD / YYYY) _____

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name _____ Physician's Signature _____ Date (MM / DD / YYYY) _____

INHERITED EYE DISORDERS TESTING REQUISITION

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ETHNICITY

- | | | |
|--|---|---|
| <input type="radio"/> African American | <input type="radio"/> Hispanic American | <input type="radio"/> Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia) |
| <input type="radio"/> Ashkenazi Jewish | <input type="radio"/> Mennonite | <input type="radio"/> South Asian (India, Pakistan) |
| <input type="radio"/> East Asian (China, Japan, Korea) | <input type="radio"/> Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) | <input type="radio"/> Southeast Asian (Vietnam, Cambodia, Thailand) |
| <input type="radio"/> Finnish | <input type="radio"/> Native American | <input type="radio"/> Southern European Caucasian (Spain, Italy, Greece) |
| <input type="radio"/> French Canadian | <input type="radio"/> Northern European Caucasian (Scandinavian, UK, Germany) | <input type="radio"/> Other (Specify): _____ |

INDICATION FOR TESTING (REQUIRED)

- Symptomatic (Summarize below) Symptomatic with Family History
- _____
- Asymptomatic
- Population Screening Positive Family History

Disease _____ Gene _____ Variant _____

ICD10 Diagnosis Code(s): _____

TESTING OPTIONS

- Targeted Sequencing for Known Familial Mutation (If selected, specify test code and gene below and complete section to the right)
- Test Code _____ Gene _____
- Full Gene Sequencing
- Deletion/ Duplication Analysis

SAMPLE

- SAMPLE TYPE**
- | | |
|---|---------------------------------------|
| <input type="radio"/> Blood in EDTA-tube (purple-top) | <input type="radio"/> Liver |
| <input type="radio"/> Blood in Heparin-tube (green-top) | <input type="radio"/> Saliva |
| <input type="radio"/> DNA | <input type="radio"/> Skeletal Muscle |
| <input type="radio"/> Other (Specify) _____ | <input type="radio"/> Tissue |

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

_____ / _____ / _____
 Date of Collection (MM/DD/YY)

FOR TARGETED TESTING SELECTION ONLY

Proband Last Name _____ Proband First Name _____

_____ / _____ / _____
 Date of Birth (MM/DD/YY) Relationship of Proband to Patient _____

Proband testing location (Select one)

Baylor Genetics Lab# _____ Family# _____

Another laboratory 1. Attach a copy of the Proband test results
 2. A positive control sample of the Proband is requested.
 Please provide, if available.

INHERITED EYE DISORDERS TESTS

CYTOGENETIC TESTS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
<input type="checkbox"/> 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH		
<input type="checkbox"/> 8655	Chromosomal Microarray Analysis (CMA) - HR	BE + BH		

MITOCHONDRIAL DNA (MTDNA) MUTATION SCREENS

TEST CODE	TEST NAME	SAMPLE TYPE*
<input type="checkbox"/> 2010	Advanced mtDNA Point Mutations and Deletions by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SM, T
<input type="checkbox"/> 2055	Comprehensive mtDNA Analysis by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, DNA, L SM, T

* Refer to Sample Specifications Table (page 5)



INHERITED EYE DISORDERS TESTING REQUISITION

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Patient First Name

MI

____ / ____ / ____
Date of Birth (MM / DD / YYYY)

Biological Sex

FISH STUDIES

MASSIVELY PARALLEL SEQUENCING (BCM-MITOMENGSSM) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE*	TEST CODE	TEST NAME	SAMPLE TYPE*
<input type="checkbox"/> 20100	Albinism Panel (13 genes)	BE, DNA	<input type="checkbox"/> 5255	Primary Open Angle Glaucoma Panel (MYOC, OPTN)	BE, DNA
<input type="checkbox"/> 5260	Developmental Glaucoma Panel (8 genes)	BE, DNA	<input type="checkbox"/> 2140	Progressive External Ophthalmoplegia Panel (10 genes)	BE, DNA
<input type="checkbox"/> 5250	Familial Exudative Vitreoretinopathy Panel (FZD4, LRP5, NDP, and TSPAN12)	BE, DNA	<input type="checkbox"/> 2190	Retinitis Pigmentosa + RPGR orf15 by NGS (66 genes)	BE, DNA
<input type="checkbox"/> 5090	Leber Congenital Amaurosis Panel (19 genes)	BE, DNA	<input type="checkbox"/> 2195	Usher Syndrome Panel (9 genes)	BE, DNA

DNA COPY NUMBER ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST			
<input type="checkbox"/> 2000	MitoMet®Plus aCGH Analysis	BE				
<input type="checkbox"/> 2001	Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE				
<input type="checkbox"/> 2003	Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE				

SINGLE GENE ANALYSIS

If a test is not found on this form, please obtain the test code from our website (www.BMGL.com) and write in the below space(s).

_____ Test Code	_____ Gene	_____ Test Code	_____ Gene	_____ Test Code	_____ Gene
_____ Test Name		_____ Test Name		_____ Test Name	

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
<input type="checkbox"/> 6603	ABCA4 Comprehensive (Seq. & Del/Dup Analysis)	ABCA4-Related Disorders	BE
<input type="checkbox"/> 2924	BEST1 Comprehensive (Seq. & Del/Dup Analysis)	BEST1-Related Disorders	BE
<input type="checkbox"/> 2419	CEP290 Comprehensive (Seq. & Del/Dup Analysis) CEP290	CEP290-Related Disorders	BE
<input type="checkbox"/> 6655	CDH23 Sequence Analysis	CDH23-Related Disorders	BE
<input type="checkbox"/> 6660	CLRN1 Sequence Analysis	CLRN1-Related Disorders	BE
<input type="checkbox"/> 7521	COL2A1 Comprehensive (Seq. & Del/Dup Analysis)	COL2A1-Related Disorders	BE
<input type="checkbox"/> 2389	CDHR1 Comprehensive (Seq. & Del/Dup Analysis)	Cone-Rod Dystrophy 15	BE
<input type="checkbox"/> 2849	CRB1 Comprehensive (Seq. & Del/Dup Analysis)	CRB1-Related Disorders	BE
<input type="checkbox"/> 2954	CRX Comprehensive (Seq. & Del/Dup Analysis)	CRX-Related Disorders	BE
<input type="checkbox"/> 29215	CYP1B1 Sequence Analysis by NGS	CYP1B1-Related Disorders	BE, DNA
<input type="checkbox"/> 29260	TSPAN12 Sequence Analysis by NGS	Exudative Vitreoretinopathy 5	BE, DNA
<input type="checkbox"/> 29255	FZD4 Sequence Analysis by NGS	FZD4-Related Disorders	BE, DNA
<input type="checkbox"/> 2439	GUCY2D Comprehensive (Seq. & Del/Dup Analysis)	GUCY2D-Related Disorders	BE
<input type="checkbox"/> 5280	OAT Sequence Analysis	Gyrate Atrophy of Choroid and Retina	BE
<input type="checkbox"/> 2789	IMPDH1 Comprehensive (Seq. & Del/Dup Analysis)	IMPDH1-Related Disorders	BE
<input type="checkbox"/> 2394	LCA5 Comprehensive (Seq. & Del/Dup Analysis)	LCA5-Related Disorders	BE

* Refer to Sample Specifications Table (page 5)

Continued on next page



INHERITED EYE DISORDERS TESTING REQUISITION

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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
<input type="checkbox"/> 5084	CABP4 Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
<input type="checkbox"/> 5069	IQCB1 Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
<input type="checkbox"/> 6039	OCRL Sequence Analysis	Lowe Syndrome	BE
<input type="checkbox"/> 2839	LRAT Comprehensive (Seq. & Del/Dup Analysis)	LRAT-Related Disorders	BE
<input type="checkbox"/> 29265	LRP5 Sequence Analysis by NGS	LRP5-Related Disorders	BE, DNA
<input type="checkbox"/> 2409	MFRP Comprehensive (Seq. & Del/Dup Analysis)	Microphthalmia, Isolated 5 Disorder	BE
<input type="checkbox"/> 29270	NDP Sequence Analysis by NGS	NDP-Related Disorders	BE, DNA
<input type="checkbox"/> 6083	X-Linked, GPR143 Comprehensive (Seq. & Del/Dup Analysis)	Oculocutaneous Albinism	BE
<input type="checkbox"/> 3469	Type 1, OPA1 Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
<input type="checkbox"/> 3529	Type 3, OPA3 Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
<input type="checkbox"/> 29250	OPTN Sequence Analysis by NGS	OPTN-Related Disorders	BE, DNA
<input type="checkbox"/> 29235	PAX6 Sequence Analysis by NGS	PAX6-Related Disorders	BE, DNA
<input type="checkbox"/> 29240	PITX2 Sequence Analysis by NGS	PITX2-Related Disorders	BE, DNA
<input type="checkbox"/> 29220	PITX3 Sequence Analysis by NGS	PITX3-Related Disorders	BE, DNA
<input type="checkbox"/> 2414	ABHD12 Comprehensive (Seq. & Del/Dup Analysis)	Polyneuropathy, Hearing Loss, Ataxia, Retinitis Pigmentosa, and Cataract Disorder	BE
<input type="checkbox"/> 29245	MYOC Sequence Analysis by NGS	Primary Open Angle Glaucoma 1A	BE, DNA
<input type="checkbox"/> 2959	RDH12 Comprehensive (Seq. & Del/Dup Analysis)	RDH12-Related Disorders	BE
<input type="checkbox"/> 2964	C2orf71 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2764	CA4 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2944	CNGB1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2969	DHDDS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2974	EYS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2994	FAM161A Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2769	FSCN2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2454	IMPG2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2984	MERTK Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2459	PDE6B Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2399	PROM1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2799	PRPF31 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2939	PRPH2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2479	RGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2474	RLBP1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2814	ROM1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2449	RP2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2359	RPGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2484	SAG Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
<input type="checkbox"/> 2894	TOPORS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE

* Refer to Sample Specifications Table (page 5)

Continued on next page



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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
<input type="checkbox"/> 29540	RS1 Sequence Analysis by NGS	Retinoschisis	BE, DNA
<input type="checkbox"/> 2934	RPE65 Comprehensive (Seq. & Del/Dup Analysis)	RPE65-Related Disorders	BE, DNA
<input type="checkbox"/> 2354	RPGRIP1 Comprehensive (Seq. & Del/Dup Analysis)	RPGRIP1-Related Disorders	BE, DNA
<input type="checkbox"/> 2899	PRKCG Comprehensive (Seq. & Del/Dup Analysis)	Spinocerebellar Ataxia 14 (SCA)	BE, DNA
<input type="checkbox"/> 6650	USH2A Sequence Analysis	USH2A-Related Disorders	BE, DNA
<input type="checkbox"/> 2379	Type 1C, USH1C Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
<input type="checkbox"/> 2374	Type 1F, PCDH15 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
<input type="checkbox"/> 2369	Type 2C, GPR98 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
<input type="checkbox"/> 2364	Type 2D, DFNB31 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
<input type="checkbox"/> 29230	VSX1 Sequence Analysis	VSX1-Related Disorders	BE, DNA

* Refer to Sample Specifications Table below

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
BE	Blood in EDTA tube (purple-top)	10 cc	2 - 3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BH	Blood in Sodium Heparin tube (green top)	3 - 5 cc	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
DNA	DNA, Extracted	10 - 15 ug	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Minimal concentration of 50ng/uL; A260/A280 of ~1.7
L	Liver	10 - 15 mg	2 - 3 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Liver should be flash frozen in liquid nitrogen at collection with no media added and stored at -80°C.
SA	Saliva	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit.
SM	Skeletal Muscle	150 mg	150 mg	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Skeletal Muscle should be flash frozen in liquid nitrogen at collection with no media added, and stored at -80°C. Surgical pathology report required. If a pathology report is not available at this time, please send a clinical summary and the results of any pertinent ancillary testing.
T	Tissue	50 mg	50 mg	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Tissue should be flash frozen in liquid nitrogen at collection with no media added, and stored at -80°C.

INFORMED CONSENT FOR INHERITED EYE DISORDERS TESTING

Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Biological Sex

INFORMED CONSENT FOR GENETIC TESTING

TEST INFORMATION

This consent form will provide you with information regarding genetic testing, which you should discuss with your healthcare provider or a genetic counselor. In order to ensure that you have understood the purpose and significance of genetic testing, we have provided information about the testing process and potential results below.

The purpose of genetic testing is to identify the cause of a suspected disease in you or your family. The testing analyzes your genetic material (DNA) for an abnormal change (variant) that could explain the disease you or members of your family are experiencing. Genetic testing can be a diagnostic test, which is used to identify or rule out a specific genetic condition. Genetic screening tests are used to assess the chance for a person to develop or have a child with a genetic condition. Genetic screening tests are not typically diagnostic, and results may require additional testing.

The purpose of this test is to see if you or your child may have a genetic variant or chromosome rearrangement. This may cause a genetic disorder or may determine the chance that you or your child will develop or pass on a genetic disorder in the future. "Your child" can also mean your unborn child, for the purposes of this consent.

In a genetic test, depending on the case, you can be tested for:

- A single gene/variant responsible for a specific, suspected genetic disease.
- Multiple genes in parallel.

The sample/specimen that is needed to perform the genetic test is stated in the test order form and is typically blood or purified DNA, but may also be tissue, saliva or buccal swab.

RESULTS

There are several categories of test results that may be reported including:

- **Positive:** Positive or "abnormal" results mean there is a change in the genetic material found that is related to your/your child's medical issues or that you/your child are at an increased risk of developing the disorder in the future. It is possible to test positive for more than one genetic variant.
- **Negative:** Negative or "normal" results mean no relevant genetic change related to your/your child's medical issues was detected. This does not mean there is no genetic change, but it may mean that the type of testing performed could not detect it.
- **Results of Unclear Significance:** Testing can detect change(s) in DNA which we do not yet fully understand. These alterations are also referred to as variants of uncertain significance (VUS). Additional studies may be recommended if a VUS is identified in a gene that may be associated with your/your child's medical concerns.
- **Secondary / Incidental Findings:** Testing can sometimes detect a change in a person's DNA unrelated to the reason for testing. If this change has medical or reproductive significance, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- Results may indicate affected status, increased risk to someday be affected with, and/or reproductive risk for a genetic disorder. It is important to understand that genetic tests, even if negative, are not exhaustive. It is not possible to exclude risks for all possible genetic diseases for yourself and your family members.
- A positive test result is an indication that the individual(s) being tested may be predisposed to or have the specific disease or condition which prompted testing. You might consider additional independent testing, consult a personal physician, or pursue genetic counseling.
- It is possible that the knowledge of the test results may result in psychological stress for you and your family. It is always recommended to discuss the results with your healthcare provider or genetic counselor.
- If several family members are tested, the correct interpretation of the results depends on the provided relationships between family members. In rare cases, genetic testing can reveal that the true biological relationships in a family are not as they were reported. If a discrepancy is identified, it may be necessary to report this to the physician who ordered the testing.
- Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons include, but are not limited to, mislabeled samples, inaccurate reporting of clinical/medical information, or rare technical errors.
- If you sign this consent form, but you no longer wish to have your sample(s) tested, you can contact your physician to cancel the test. If testing is complete, but you have not received your results yet, you can inform your physician that you no longer wish to receive the results. If you withdraw consent for testing after 5pm CST the next business day following sample receipt by the laboratory, you will be charged for the full cost of the test.

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION

- Results will only be released to a licensed healthcare provider, to those allowed access to test results by law, and to those authorized in writing.
- In rare cases, persons with genetic diagnoses have experienced problems with insurance coverage and employment. The U.S. Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, you can visit www.genome.gov/10002077.
- Samples will be retained in the laboratory in accordance with the laboratory retention policy.
- After testing is complete, the de-identified submitted specimen may be used for test development and improvement, internal validation, quality assurance, and training purposes. DNA specimens are not returned to individuals or to referring health care providers unless specific prior arrangements have been made.



INFORMED CONSENT FOR INHERITED EYE DISORDERS TESTING

_____ / _____ / _____
Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Biological Sex

INFORMED CONSENT FOR GENETIC TESTING

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION (CONT.)

- Samples from residents of New York State will not be included in the de-identified research studies described in this authorization and will not be retained for more than 60 days after test completion, unless specifically authorized by your selection. No tests other than those authorized shall be performed on the biological sample.
- Information including results, indications for testing and clinical status obtained from this testing may be shared with healthcare providers, scientists and healthcare databases or used in scientific publications or presentations, but the personal identifying information of all persons studied will not be revealed in such data sharing or publications/presentations.

RESEARCH & RECONTACT CONSENT

For more information on research at Baylor Genetics, please visit baylorgenetics.com. Please read the below statements carefully and check the appropriate box.

Note: If left blank, consent is interpreted as "NO."

- I agree to use of my de-identified specimen for research to improve genetic testing for all patients and contribute to scientific research.
 - I am a New York State Resident, and I give Baylor Genetics permission to store my specimen in accordance to the laboratory retention policy for internal quality assurance and possible research studies.
- In addition to agreeing above, I agree to be contacted by Baylor Genetics regarding research opportunities.

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read and understand the informed consent for genetic testing. I have received appropriate explanations from my physician regarding the purpose, scope, type and significance of the planned genetic testing and achievable results. All my questions have been answered and I have had the necessary time to make an informed decision about the genetic test.

I give permission to Baylor Genetics to conduct genetic testing as recommended by my physician.

_____ Date (DD/MM/YYYY)
Patient Signature

Printed Name